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THE JOURNAL OF SCHOOL HEALTH

*Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.*

Vol. XIX FEBRUARY, 1949 No. 2

# SOME TRENDS IN HEALTH INSTRUCTION AS RELATED TO THE STUDENT HEALTH SERVICE

A. O. DEWEESE, M.D.

At the Sixteenth Annual Meeting (1935) of the American Student Health Association, the Health Instruction committee gave a report on a study made on the organization and administration of College hygiene. This report was based on a study of one hundred four institutions from a total membership of one hundred twenty-six. When the medical schools, technical schools and two year normal schools were excluded, their study included all but seven of the remaining member institutions.

It was thought that a somewhat similar study now, thirteen years later, might show some trends in Health Education on the University and College level.

In the meantime the membership has increased about sixty. Excluding the same type schools as were excluded in the previous study, we were able to get reliable data on all but about twenty-five schools in the membership. This study includes one hundred thirty-one Colleges and Universities, with a total enrollment of four hundred eleven thousand seven hundred and seventy-six students.

*Physicians in the Health Services,*—First a check was made of the number of physicians and their status in the one hundred and thirty-one Health Services. This was to determine if the changing conditions of the last few years had produced any great dearth of physicians in student health work. This investigation showed the following:

(a) 106 of the one hundred and thirty-one health services have one or more full time physicians.
(b) 25 health services have only part time physicians.
(c) 49 health services are staffed entirely by full time physicians.
(d) 82 health services have one or more part time physicians in addition to the full time physicians.
(e) 354 is the total number of full time physicians in the 131 health services.

(f) 365 is the total number of part time physicians.
(g) 411,767 is the total student enrollment in the 131 institutions.
(h) 1163 is the average number of students per one full time physician.
(i) 1128 is the average number of students per each part time physician.

These findings would seem to indicate that there is not the dearth of physicians in student health work that we could reasonably expect. We have one full time physician and one part time physician on the average for approximately every 1145 students. This closely approximates the standards set by this Association and other related organizations that there should be one full time physician for every 750 to 1000 students.

*Required Courses with Credit in Health,*—The American Student Health Association has contended for a quarter of a century that a sound scientific knowledge of the principles underlying personal and community hygiene should be a prerequisite for a College degree. The objectives, skills techniques and materials for such a course required of all college students with credit appear in most every copy of its annual proceedings. The results of the study on this problem are as follows:

(a) 54.8% of the member institutions required such a course in the 1935 study.
(b) 42% of the member institutions required such a course in 1948.
(c) 2½ semester hours was the average credit allowed in 1935. 3 semester hours was the average credit allowed in 1948.
(d) In 1935, thirty-one schools allowed two semester hours credit; sixteen, one semester hour; six, three semester hours; and four, four or more semester hours credit.
(e) In 1948, fourteen schools allowed two semester hours credit; fourteen, one semester hour; eleven, three semester hours; and fifteen schools allowed four or more semester hours of credit.

Nine schools had a required course in hygiene without credit.

This drop of 12.8% in the number of schools requiring a course in health of all college students, seems to indicate a recession in this endeavor. Various reasons are given by different universities for dropping the requirement.

The preparatory schools are placing more emphasis upon

health instructions. Several years ago this association devised some health information tests for college freshman. A few universities give these or similar tests and excuse students from the required course if the student passed the test. This naturally led some schools to infer that the course could be abandoned as a freshman course in hygiene would be too elementary for the average college freshman.

The health instruction committee some years ago recommended that the required course in hygiene be made more comprehensive including personal, community and international health and be given in the upper division instead of in the freshman year. This study showed that the required course is distributed as follows:

(a) 42 institutions still require the course in the first year.

(b) 9 institutions require it in the second year.

(c) 4 institutions require it in the third year.

*Elective Courses in Health,*—The annual proceedings of the Association for the past twenty-nine years show that we have also led a persistent fight for elective health courses for all students in undergraduate study. That the response of college administrations to this endeavor has been more favorable is shown by the following:

(a) 80 institutions offer one or more elective courses in health.

(b) 346 is the total number of courses offered.

(c) 4⅓ courses is the average number offered.

(d) 1073 semester hours is the total hours of electives.

(e) 13.4 semester hours is the average number of hours offered per school.

*A College Major or Minor in Health,*—Another indication of increased emphasis on the part of our colleges and universities in health instruction is shown by the number of schools which have recently added a College Major or Minor in health, separated from health and physical education in their curriculum. Twenty-six institutions of the one hundred thirty-one institutions studied now offer a separate major or minor in health. Many indicated that such a major was in the processes of being added. Others indicated that such a major was being contemplated. With one-fifth of our colleges now offering a separate major in health and many contemplating it, we have an innovation that is phenomenal for conservative college curriculums. One explanation that has been given for this is that after the first world war the national interest

in health was capitalized upon by Health, Physical Education and Recreation. Due to circumstances beyond their control, this group was forced into a major program of activities and sports with little emphasis upon or time for health. This condition left a wide opening for the Health Educator as separate and distinct from physical education, recreation and sports to capitalize upon the national interest in health engendered by the last world war.

This may or may not be true, but the fact remains that the latest newcomer to our college campuses is the Health Specialist and the Professional Health Educator, as a separate and distinct individual from the old group of health, physical education and recreation specialist.

*The Relation of the Health Service to Health Instruction.*—The record plainly shows that it is this association that gave birth to, and nurtured through its infancy, health knowledge and instruction for the college student. The earlier proceedings of our association show that the first members of this body were greatly appalled at the ignorance found in our college groups of the simplest scientific facts relative to hygiene. They were much concerned for the future of America, if these college men and women in training for leadership were graduated from our educational institutions so steeped in ignorance relative to such an important social and civic factor. They pointed out the fact that personal, community and public health was a most important element of citizenship if people were to live successfully under complex civilized conditions.

The older members of this body were vigorously championing the cause of health education when it was quite unpopular to do so. In the annual meeting of 1929, Dr. Sundwall of Michigan said: "We trust that the time is not far distant, and it is our job to hasten its forthcoming, when the administration and the faculty of a College and University will forcefully sense the utmost importance of seeing to it that each young man, each young woman, upon whom a degree is conferred and, therefore, is underwritten by the college and university, is equipped with that knowledge and those attitudes and practices which will assure, in the very largest measure, a longlasting, vigorous, harmoniously developed body machine. Until that time comes college hygiene has not functioned adequately and the college administration will continue to graduate students who will not measure up to the specifications which society requires of the college student.

The time has come when we should no longer take a servile

demeanor toward college hygiene and its related activities, nor should we tolerate the condescending attitude toward it by our fellow academicians. We must insist upon and command respect for college hygiene."

So the Health Services gave birth to college health instruction under the most favorable conditions. They nurtured and protected it through perilous and stormy times. Now that it has grown strong and popular, they are rapidly turning it over to lay groups. This is true if we interpret correctly the following facts brought out in this study.

*Physicians Teaching Health,*—Fewer physicians of our health services are taking any part in Health Teaching. The comparison between the 1935 study and the 1948 study is as follows:

1935—104 Institutions

(a) 71% or 74 schools had one or more physicians from the health service engaged in teaching.
(b) 29% or 30 had no members so engaged.
(c) 3.95 semester hours was the average teaching load.

1948—131 Institutions

(d) 29% or 39 schools had one or more physicians from the health service engaged in teaching.
(e) 71% or 92 schools had no members so engaged.
(f) 3.25 semester hours was the average teaching load.

MAJOR DEGREES HELD BY HEALTH TEACHERS

College health instruction is rapidly being taken over by lay health teachers as is shown by the following comparison:

In the 1935 study of 104 schools, the major degree held by the College teachers of health was as follows:

M.D. 151: Ph.D. 27: Dr. P.H. 9: A.M. 92: A.B. 21: R.N. 2.

In the 1948 study of 131 schools the major degree held by the college teachers of health was as follows:

M.D. 78: Ph.D. 78: Dr. P.H. 26: A.M. 111: A.B. 42: R.N. 9.

In 1935, seventy-one percent of college health teachers held an M.D. degree. In 1948, the number had shrunk to twenty-three percent. If we take into account that the average teaching load of the physicians was only 3.25 semester hours, we see that the health instruction by physicians is quite insignificant in so far as the total hours of health teaching that is now being done in our colleges and universities.

*Supervision of Health Instruction,*—Should the student health service with its physicians trained in the medical and public health sciences, have any supervision over what is taught as health in

our Universities and Colleges? This question, according to present day trends, has been answered in the negative by our college administrators as is shown by the following:

1935—104 Schools

(a) 63% (60 schools) gave to the Student Health Service the supervision of health instructors.

(b) 37% (34 schools) had no supervision by the health services.

1948—131 Schools

(c) 16% (20 schools) gave to the Student Health Service the supervision of health instruction.

(d) 84% (106 schools) had no supervision by the Student Health Services.

*The Health Co-ordinator,*—The latest addition to our college faculties is the so-called health co-ordinator. His duties are vaguely defined as the co-ordinator of all the health facilities upon the campus. The national and district health conferences that have attempted to define the duties of the Co-ordinator have divided on the question as to whether he should belong to the personnel or administrative staff. The entire future of the usefulness, efficiency and worthwhileness of the student health service depends upon how this question is finally decided.

Twenty-seven of the one hundred thirty-two member institutions now have a health co-ordinator on the faculty. Many more state that such an addition is contemplated. If the present trend continues, all of our institutions will soon have such a Health Co-ordinator.

What is the major degree held by the twenty-seven co-ordinators now on our faculties. Twelve have M.A. degrees: eleven have Ph.D. degrees: and four have M.D. degrees.

Better than one-fifth of your colleges and universities have in a very short period of time established on their campus a Health Co-ordinator. The indications are that within the next two years fully half of the institutions of higher learning will have established some such an official. Only one and one-half percent of those now functioning are medically trained, and there are no indications or findings that even this small percent will be maintained in future expansion.

*Conclusions,*—The study indicates that in our institutions of higher learning the clinical health services are well organized for efficient student medical services. There are many weak spots, but on the average eighty-two percent of our institutions have one or

more full time physicians. There is on the average of one full time physician and one part time physician for every 1145 students.

The School and University physicians, after a number of years of hard and tireless effort introduced an organized program of Health Education into the College and University curriculum. Their efforts were coordinated through the two national organizations, The American Student Health Association and the American Association of School Physicians (The American School Health Association). Since its introduction the Health Education program has been taken over by lay professional groups.

On the whole this has enlarged, expanded and vitalized the health education program. It has been a natural growth and development to fulfill an educational need. Non-medical workers specializing in various phases and techniques of the complex field of health were necessary before the science of health could be brought to the masses of our population.

On the other hand, it might be deplored that the medically trained group is losing its influence in the supervision and direction of the Health Education movement. Sooner or later the lack of this balanced direction is bound to react upon the entire Health program. The specialist even if medically trained is prone to overevaluate as a whole, and to disrupt the economic balance of medical care. The lay specialist in health education is even more prone to make the same mistakes and disrupt a well balanced health education program that is economically and scientifically sound.

* * * * *

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## MEETINGS

State Society Directors of Health, Physical Education and Recreation, Boston, Mass., April 16, 17, 18, 1949.

American Association of Health, Physical Education and Recreation, Boston, Mass., April 17 to 23, 1949.

# EVALUATING HEALTH EDUCATION OUTCOMES

WILLARD W. PATTY, DEAN
*School of Health, Physical Education, and Recreation*
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There are those who feel that testing health education outcomes may spoil the effects of the educational program. They hold that testing introduces an artificial element into a health education program. They believe that health education is so vital to the success and happiness of children that testing might detract from its effectiveness. Might not one better ask why we are justified in measuring learning outcomes in any subject that is not vital to the child?

## NATURE OF HEALTH EDUCATION

What is the principal function of the health education program? The World Health Organization has recently adopted a *definition for health*: "Health is a state of complete physical, mental, and social well-being, and not merely freedom from disease or infirmity." Is it not apparent that the major function of the health education program is to help to conserve the well-being of members of the school community, especially of pupils and school staff?

*Enemies from without and within.* A pecularity of the health problem of each individual is that there are enemies to personal well-being both from within the human organism and in the environment surrounding it. Within the organism may be such harmful factors influencing health as: a defective nervous system; specific allergies; unsound misconceptions concerning medical "cure-alls, "quack doctors", and health superstitions; malnutrition; irregular habits of physical activity and sleep; and reckless attitudes toward personal conduct. Enemies from without include such dangerous influences as: unfavorable climatic conditions; unsanitary environment; immoral companions; associates who are communicable disease carriers; irritating personalities in family or working group; traffic dangers; occupational health and safety hazards; and improper heating, ventilation, and lighting in home or school and place of employment.

*Knowledges, attitudes and habits important.* It is not apparent that all of these kinds of outcomes of health and safety education are important? Accurate health knowledge does not guarantee correct conduct. Right attitudes toward health values and procedures influence the individual to apply his knowledge. Correct

health habits actuate the child to react properly to stimuli in a familiar environment.

Are knowledge outcomes unimportant? While the statements in the preceding paragraph are generally accepted as true, one should not conclude that accurate knowledge concerning factors which affect health is not valuable. Knowledge gives meaning to emotional attitudes and fixed habits. It strengthens them. Moreover, the human organism does not always operate in a familiar environment. People are becoming more transient with each passing decade. Attitudes and habits are specific. They relate primarily to stimuli in the known environment. The human organism must depend upon knowledge for protection of health when moving into new environments in the varied areas of the modern world community.

If these things be true, then all three of these major classes of outcomes of health education are important.

## Measurement

*Can we measure all outcomes* of health education? It has been said that everything that exists is present in some amount, and, therefore, may be measured. This concept seems to be almost universally accepted. Does this mean that we can measure accurately all outcomes? No. It implies the possibility but not, necessarily, the power to measure. A reasonable position seems to be that: (1) we now have satisfactory tools with which to measure some kinds of outcomes of the educative process, and (2) we need to work for the development of techniques to evaluate others.

## Habits and Skills

*How may we check on the pupil's health habits and skills?* Attempts have been made to secure information concerning the habits of pupils by having them write answers to questionnaires or to check lists dealing with health practices. The concensus of opinion is that such pupil answers rate low in validity. It is thought that the pupil will often answer what he thinks will please the teacher or will avoid punishment, rather than giving the truth concerning habits actually practiced.

Observation of the health habits of pupils by the teacher promises best results in habit evaluation. Home room, general elementary classroom, and physical education teachers usually have the most favorable opportunities.

It may be felt that it is desirable to enlist the parents to aid in the evaluation program by keeping a record of home health

habits practiced by their children. It is doubtful whether parent reports concerning such observations constitute valid and reliable measures of pupil habitual conduct. Probably the principal value of such a parent-observation program would be in the development of increased interest, by parents, in the health program.

Skill in the various physical activities of children is unquestionably an important factor in health. Tests of skills used commonly in daily living activities of children might contribute significantly to the health program. Administering physical education tests to pupils might have indirect values to health.

*Why is physical skill a factor* influencing the health of an individual? Good posture while sitting, standing, and moving keeps physical fatigue at a minimum. Grace of movement is a stimulus to sound emotional health in the same manner as a clear complexion, attractive hair, clean teeth, normal vision, and other similar personal characteristics that contribute to self-confidence. Special proficiency in social dancing contributes to poise and emotional health. Prowess in athletic sports brings social approval which in turn stimulates emotional health.

Moreover, one possessed of a special physical recreational skill enjoys the kinesthetic pleasure of coordinated movement. He also enjoys the feeling of success in a social group. These effects of skillful movement motivate the individual to participate often in wholesome physical activities contributing to physical health.

Adaptations of existing physical education tests so as to measure speed, agility, strength, balance, and time reactions would serve both as incentives and for remedial teaching. However, skill tests are not, technically, in the health education test field.

## Attitudes

*How may we evaluate health attitudes?* It is generally believed that the child's attitudes are essentially emotional. Probably there is a considerable proportion of the intellectual intermingled with emotional phenomena in many attitudes. An example might be the attitudes of respect for and confidence in properly qualified physicians, dentists, and nurses.

Since attitudes consist chiefly of emotional factors, they are difficult to measure objectively. In the field of health we are concerned about such attitudes as: (1) respect for the human organism, (2) a feeling of responsibility for protecting associates from a communicable disease which one may have, (3) a desire for abundant health, (4) a dislike for insanitary or unhygienic conditions, (5) confidence in qualified medical practitioners,

(6) enjoyment of correct health practices, (7) a wholesome fear of communicable diseases, and other similar attitudes toward major factors influencing health. There are also many specific attitudes of importance related to smaller or more detailed factors such as: (1) preference for certain foods, (2) a liking for specific physical activities contributing to maintaining health, (3) enjoyment of desirable friendships, and many others.

The importance of health attitudes as outcomes of the educational program is recognized as especially important to children of elementary school age. However, attitudes are also important to high school pupils and to adults. It is natural and proper, therefore, that an effort be made to evaluate these outcomes.

*Observation.* The most promising device used seems to be that of teacher observations of pupil attitudes evidenced in school situations. If the teacher is sufficiently impressed by the importance of such evaluation, he or she may keep a record day by day of specific attitudes demonstrated by various pupils. If such notations are filed habitually in the personnel folders of pupils, they may constitute an important practical evaluation of attitudes. Such notations may include such items as: (1) the pupil's likes and dislikes of various foods, (2) his emotional relationships to fellow pupils, members of his family, the teacher, and to the school organization and physical environment. Similar observations and records made by parents in the home and general community would also contribute to attitude evaluation, if we could depend upon scientific attitudes among parents. As was stated concerning habits, parent-participation in such a program of attitude evaluation is not to be recommended as a dependable measuring device, but may be valuable educationally to parents and to children.

*Story tests.* Perhaps "story tests" give greatest promise of objective measurement of health attitudes among the "pencil and paper" health tests thus far developed. Dr. Raymond Franzen and associates constructed a story test as one of the group of five health education tests sponsored by the American Child Health Association in 1929. In commenting upon the difficulties of measurement of health attitude outcomes, Dr. Franzen states[1]:

"But such objectives as character, thrift, and health attitudes are so much a part of all other subjects that it is hard to precipitate them from the turmoil of school life. This makes measurement more difficult, but also more imperative."

1. Franzen, Raymond: Health Education Tests, School Health Research Monographs, Number I, American Child Health Association (1929). pp.27.

A later test in more condensed form was developed by Franzen, Derryberry, and McCall in 1933 under the title, "Health Awareness Test." The first section of this test consists of four stories in which situations good for health and others that are bad for health are presented.

The technique used in securing pupil reactions in these story tests is to have the pupil underline those words indicating procedures or things that are good for health, and cross out everything that is bad for health. It is believed that attitudes of children are measured by these story tests primarily because of the lifelike situations to which pupils are required to react. It seems probable that no test of health attitudes could be developed in which health knowledge would not be a factor influencing reactions. Likewise it seems unjustifiable to conclude that health attitudes play no part in a pupil's answers to health knowledge questions, especially "true-false" and "best-answer" types. Probably the soundest conclusion is that no test can be devised which tests one kind of health education outcome solely. However, it seems that "complete-recall" questions test health knowledge almost exclusively: the "true-false", "best-answer", and "matching" questions obtain answers influenced by attitudes as well as knowledge; and the health "story test" is the best effort to measure health attitudes by "pencil and paper" test methods.

## Health Knowledge Tests

If accurate health knowledge does not insure correct conduct, why test the knowledge of the pupil? Let us see how such a policy would apply to other fields of learning. If we accepted such a principle, we would eliminate all knowledge tests in social studies because not all people are perfect citizens. No knowledge tests would be given in music because some do not become musical artists. We would omit tests in mathematics classes because some people make errors in computation outside the classroom, even though taught and tested in school.

Obviously accurate knowledge does not guarantee correct conduct in any phase of living. However, if a person knows the right thing to do he may do it, while he may do the proper thing only by chance unless he knows the right course to follow.

Is it not apparent, then, that it is desirable for the school to make every effort possible to insure that each pupil possess the essential knowledge concerning health? Knowledge tests serve as checks on progress toward this goal.

*Many functions.* Tests of knowledge of health facts and prin-

ciples have many important uses. Among these are the following:

1. A health education test may be given at the beginning of a course to convince pupils of their need for the course.

2. A test may be given at the organization meeting of a course to help the teacher select units of knowledge to be stressed, or to be excluded.

3. A preliminary test together with a similar final test provide a basis for measuring pupil achievement.

4. The teacher may use preliminary and final test differences to test his own teaching efficiency.

5. The teacher may use tests to diagnose individual needs of pupils and to do remedial teaching.

6. Test results may serve as a partial basis for pupils' marks.

7. Supervisors and administrators may use such tests as aids in comparing efficiency of various teachers of health education.

8. The school staff may be interested in comparing local pupil test results with national norms.

## Conclusions

There are good reasons for attempting to evaluate health education outcomes. Commercially published tests in this field are available. The alert teacher who is well-trained will construct objective tests adapted to local conditions. The many valuables uses to which tests may be put may help to improve the quality of the health education programs and win increased support from school administrators, pupils, and the public.

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* This is the first of a series of articles on Health Education by Willard W. Patty.

## TOWARD MENTAL HEALTH*

GEORGE THOMAN

The problem presented by nervous and mental diseases is an enormous one—the most serious medical problem facing our nation. Out of every twenty-two living persons, one will spend part of his life in a mental hospital. Recent studies indicate that one out of every ten persons in the United States is emotionally or mentally maladjusted and needs treatment for some personality disorder. More than half the patients who visit their family doctor for some physical ailment are really suffering from some type of emotional disorder. Nervous and mental disease takes a larger toll than do cancer, infantile paralysis and tuberculosis combined.

Fred was a good mechanic. In fact, he was so good that his boss decided to promote him to foreman. About a week before the promotion was to be made, Fred took to his bed, said there was something wrong with his leg, and insisted that he couldn't move. X-rays were taken; general practitioners were called in. They could find nothing wrong.

What had happened to Fred? When he was to be promoted or start on a new job, he became anxious and fearful. He knew how to operate a lathe and was happy while he was doing it. But responsibility for supervising other men had him scared.

The psychiatrist—a doctor who has made a study of the emotions and the mind—diagnosed his case as hysteria, a form of neurosis. "Fred's bad leg," says the psychiatrist, "was his way of solving a problem. If he had a bad leg, he couldn't be expected to go back to work and face a situation of which he was afraid. His fears actually interfered with his walking. He was firmly convinced that he couldn't use his leg. Back of his fear of the new job as foreman were a lot of fears and conflicts which he didn't even know he had.

"He felt that he ought to take the promotion. His wife, his friends, his fellow workers all expected him to. A refusal would put him on the spot. How could be explain it? He couldn't say that he was afraid of the added responsibility. And yet he was.

"He was afraid because he thought he would fail. And he was afraid he would fail because of an earlier experience—one which he

*This material is reproduced in a condesned form from a pamphlet, Toward Mental Health, written by George Thoman, prepared in cooperation with the National Mental Health Foundation by the Public Affairs Committee, and reprinted with their permission. The pamphlet can be obtained for 10 cents from the Public Affairs Committee, Inc., 22 East 38th Street, New York 16, N. Y., as published in the Health Education Journal, Los Angeles City Schools.

had forgotten. When he was ten years old, Fred had been left to take care of his younger brother while his mother went on an errand. When she was gone, his brother ran into the street and was almost killed by an auto. When the mother came back, neighbors told her the story. She punished Fred severely and told him never, never, would he be left to take care of his younger brother again. This was an unfortunate experience in Fred's life and it left its mark. It made him panicky when he was faced with the supervision of others."

Over a long period of treatment Fred was able to find the reason for his fear and overcome it with the help of the psychiatrist. Now he is back at his old job.

John is a bachelor. For the past ten years he has been going to the family doctor because of nervous indigestion. He complains of poor appetite, dizziness, pains around his heart. Yet the doctor can find nothing physically wrong with him. It is not fair to say that John is only imagining his nervous indigestion. To him it is very real. As a matter of fact, he is sick—emotionally sick.

The real cause of John's illness is an emotional conflict which he doesn't realize. If you told him so outright, he would deny it. He does not think of himself as emotionally tied up. He will tell you that if he could get his stomach in good shape, he would be O.K. But here is what John looks like from the point of view of a doctor who understands emotional as well as physical ills.

John was an only child of an overly protective mother. He has turned all of his attention upon himself. Other men find an outlet for their energy in a job or a cause. But John is not interested in anything except himself. Consequently, he feels frustrated and unhappy. This frustration comes out in the form of nervous indigestion.

Our minds and emotions are closely connected with our bodies. Mind and body interact. Our physical condition can affect our emotions, and our emotions can affect our physical well-being. Doctors have found that more than half of the persons who visit their family physician for treatment of physical ailment suffer from emotional difficulties which partially explain their physical symptoms. For example, stomach ulcers are frequently connected with worry and anxiety. The help of a psychiatrist may be necessary—or the family doctor himself, if he approaches the patient as a person rather than as a "cardiac patient" or a "stomach case," may be able to bring relief through helping the patient to an understanding of the connection between emotions and symptoms. In

such cases, helping the patient overcome his worrying is just as important to his recovery as is proper diet and medical attention.

None of us is perfectly balanced. All of us are subject to emotional conflicts to some extent. Neurosis is one of the most common forms of emotional disorder. About one out of ten of us suffer from such disorders because of an underlying conflict. Most of these conflicts go on inside us without our knowing that they are there. We only know the symptoms; frustration, unhappiness, obsessions, strange compulsions, fears that we cannot account for, ailments that have no physical basis. The psychiatrist helps us look back of these fears, anxieties, tensions, shows us how they are connected with earlier experiences, helps us resolve our emotional conflicts. Freed of tension, we are able to solve our problems and overcome our frustrations.

In most cases these emotional difficulties do not stop us from doing our work. Neurotic people can work and take care of their personal affairs. They do need treatment, however, for their own well-being and should not hesitate to get help from a psychiatrist who has had much experience in dealing with emotional and nervous disorders. Delay in getting treatment will only bring more unhappiness, frustration, and worry.

Sometimes not only are emotions seriously disturbed, but the mind becomes confused and the whole personality is profoundly changed. These more serious types of illness which affect the emotional and mental life are called psychoses—a medical term for what we sometimes improperly call "insanity." The psychoses account for a much smaller number of persons who need psychiatric treatment, but because they are more easily recognized and more dramatic they are sometimes better known. Yet even the most severe form of psychosis may develop gradually, and it is sometimes easy to pass it by in the early stages, as we shall see in the cases of George and Mary.

We are all more or less subject to changes in mood. One week we feel on top of the world. The next we hit a slump. When these changes become extreme in nature, doctors regard it as a serious form of mental illness called *manic-depressive psychosis*. George is an example of a person who is suffering from this illness.

Most of George's friends and business associates thought he was a hard worker who never knew a day of worry in his life. He had impressed them as one of those successful people with enough energy for three persons. He worked late into the night—was at his desk early again the next morning. They often told him he

ought to take it easy, but George seemed to thrive on hard work.

He did quite well—had the highest salary in his office. Still he wasn't satisfied. Success only spurred him on to greater efforts. He began to spend his money lavishly—bought a large house, sank most of his money in a risky investment. His friends became worried about his reckless spending, but George was full of optimism, sure that he would win. He became more and more excited and was in such a state that he couldn't sleep or eat.

Then George began slowly to change. He lost his feeling of self-confidence and optimism. He was no longer sure of his business judgment, stayed away from his office, sat staring into space for hours. He said that he would surely lose his job, blamed himself for having brought ruin to his family, cried out to God to spare his soul. It was in this state of depression that he sat home all day, afraid to go to the office, afraid the telephone would ring.

Doctors are not so sure about the causes of these cases of extreme moodiness. Some cases seem to be brought on by grief or some emotional crisis. Others are not. But the psychology of the manic-depressive illness seems to be fairly clear. These persons become depressed because they feel that they are not attaining the goal which they have set for themselves. Most of them are ambitious. They are overly anxious to achieve success, and they often set their ideal far above what they can accomplish. When they find themselves falling short of their ideal, they plunge into the depths of despair.

Sometimes the illness may be due to childish emotional bonds to father or mother which the individual wants to break, but somehow cannot. At the same time that these persons want to have parental affection and guidance, they yearn for freedom from emotional ties and harbor a deep-seated resentment against those to whom they are closely bound. They are torn by intense inner conflict and turmoil.

Some of these depressed people are potential suicides. Many of the stories you read in the newspaper about someone who committed suicide because of disappointment in love or financial failure are about persons who are really mentally ill. They could have recovered and lived useful lives if their relatives had recognized their illness and placed them under treatment in time.

Many families make the mistake of thinking that the patient will "snap out of it." Melancholy persons cannot be cheered up, jollied out of their moods, or reasoned with. As soon as symptoms of moodiness are recognized, consult your physician. He may sug-

gest psychiatric advice. If the symptoms are so severe there is danger of suicide, adequate precautions must be taken. The psychiatrist will give advice on this point and can help the family physician and the patient's relatives make proper provisions for care and treatment. He will know whether institutional care is needed or desirable. The family should assume responsibility for seeking and following professional advice.

Everyone said Mary was headed for big things when she went to college. She had been the best student in her graduating class in high school and seemed on her way to a brilliant career as a concert pianist. In the middle of her second year at the state university she failed in half her subjects and at the end of the year she was forced to drop out of school.

At home Mary was flighty, irritable, and moody. Her conversation came in jerks. She would start a sentence and then be unable to finish it. She wanted to be left alone, wouldn't go out of the house, stayed up late at night reading, burst into crying spells. Her family called the doctor and Mary was sent to a mental institution.

"Mary is a victim of schizophrenia," says the psychiatrist, "one of the most common forms of mental illness found in our mental hospitals. The word schizophrenia means 'splitting of the personality' and it is a good word for this disorder because it describes what seems to happen. These patients are physically in the real world, but mentally they are in a dream world of their own—they lose contact with reality.

"In Mary's case this withdrawal from reality results in a dull state, a complete breakdown of the will to act, to move, to survive. Mary won't eat, refuses to dress, seldom talks. She just sits all day long with her legs drawn up under her chin, gazing off into space. Lift her arm and it falls back lifeless and limp; talk to her and you get no answer—no response of any kind.

"Not all withdrawals from reality take this particular form. For example, one of our patients insists that she is the wife of a famous movie actor. Another patient believes that we are trying to poison him. Such delusions are usually found in cases of schizophrenia. No amount of reasoning will change these mistaken notions. The patient clings to them desperately because they satisfy an emotional need, and he cannot seem to check his ideas against the real facts. This does not mean that the illness is unreal. It is just as real as scarlet fever."

Mary was an unhappy, lonely child dominated by a mother who never let her child play with other children, made all Mary's

decisions for her, kept her weak and dependent. Consequently, Mary was never strong enough to assert herself or rebel against her mother's tyranny. She may have wanted to rebel, but she could never bring herself to do it. The problems which Mary faced and the strain they put on her emotional life were too great for her. She had no friends to whom she could go. Her father was too absorbed in his own problems to give her any attention. Mary turned inward, withdrew completely from those around her, and finally broke under the load.

Doctors aren't entirely certain that this is a complete explanation of how schizophrenia develops. Some of them believe that this psychological explanation isn't the whole story and that someday we shall find an organic cause for schizophrenia. Perhaps it is some complicated biochemical process we haven't yet discovered. Probably the cause will be found neither completely in the body nor entirely in the mind—but in both together. For after all, man is a living being. Part of this living being is physical, but another part of it is mental and emotional.

Even though we don't know all about the causes of schizophrenia, it can frequently be cured. Cases like Mary's would probably have been labeled incurable twenty years ago. But medical science has developed new and more effctive ways of treating schizophrenia. In many hospitals shock treatment—insulin or electric—and modified forms of psychoanalysis are bringing good results.

Each year serious mental illness strikes thousands of new victims and takes its toll in human suffering and misery. Each new case means a promising career cut short, another family without a mother or breadwinner, a tremendous social and economic waste. Translated into dollars and cents, the cost of mental illness in lost earnings amounts to almost a billion dollars each year. The other costs of nervous and personality disorders greatly increase this burden. What can we do to prevent this terrific human and economic loss?

First of all, we can safeguard the mental health and happiness of our children. Prevention starts at birth. A baby is a bundle of desires and wants. He wants to be fed, to be otherwise physically comfortable. When these wants go unsatisfied the baby becomes restless, begins to cry. Feed him or change his diaper and he stops crying. If you fail to satisfy these basic desires, his whole organism is affected—his emotional life gets out of balance, he feels frustrated and unhappy. Most important of all—give your baby the love he needs and wants. Without this love and affection, he feels

lost. The strange new world into which he is born is "a buzzing, booming confusion." He needs to feel secure and protected, and he looks to his parents for this sense of security and protection. Don't fail to give it to him.

The time comes when babies must grow up and learn to do things for themselves. Some babies find it hard to break away from their mothers, and some mothers find it hard to give up their babies. Don't keep your child tied to your apron strings all his life. He needs to explore things, learn to get along with other children, and cooperate with them successfully. Encourage him to dress himself to develop new skills as he grows older. Give him freedom. If you hedge him in with all kinds of unnecessary do's and don'ts, he will be irritable, unhappy, and bad-tempered.

Give him a feeling of self-confidence by showing pleasure at what he does well. And don't compare him unfavorably with other children or with his brothers and sisters. Remember that each child has his own characteristics and rate of development. Youngsters are sensitive and feel inferior and unloved when you do this. A child needs all the self-confidence that he can muster and you can help him develop it.

All of us are afraid. It is no wonder that children have fears. Sometimes children catch their fears from parents—become afraid of snakes because mother is afraid of snakes. Some fears are caused by a feeling of insecurity. A family quarrel, for example, can make the child very disturbed and fearful. Some parents deliberately frighten their children with threats of bogeymen, goblins, or policemen. This is extremely cruel.

It is a mistake to try to shame the child out of his fears because they are very real to him. A feeling of being loved, calm assurance, and an explanation that there is nothing to be afraid of is the best cure. You can sometimes take the child's mind off his fears by telling him an exciting story or getting him to play his favorite game. Often just the physical presence of the parents is enough to give the child a feeling of security.

"I don't know what I'm going to do with Johnny. He won't go to school half the time, and when he does go the teacher sends notes home that he has been a bad boy." This is an old story—Johnny's not getting along well in school.

Why is he loud and why is he always getting into trouble? Maybe it's the only way he has of getting a reputation for himself. Maybe he can't work arithmetic problems as fast as Jimmy or play ball as well as Harry. Consequently, he feels inferior—he, too, wants recognition. Making noise is one way of getting it. He

becomes anxious and loses his self-control.

Why doesn't he want to go to school? The reason he gives may not be the real one. The real trouble may not be school or Johnny, but something no one has taken the trouble to find out. Maybe he hates his father. Everytime Johnny thinks of school he thinks of father. Why, Because in school you have to behave yourself, and if you don't you get punished. So Johnny stays away from school because it reminds him of father's authority, father's scolding, father's whipping.

Once we have learned to understand why Johnny acts as he does, we can begin to help him with his problems. In many communities mental hygiene clinics and child guidance centers do this very thing. Frequent conferences between teachers, parents, social case workers, child psychologists, and child psychiatrists can do lot to change Johnny from a misunderstood boy to a happy one.

About the time that Johnny starts to school (if not considerably sooner) he becomes interested in sex. He will probably begin to ask a lot of questions about it. The chances are he has heard a number of things about sex from other children at school. Maybe he will begin showing off some obscene words he has learned—words of which he doesn't know the meaning. He will probably play with his genitals.

This is not the time to take Johnny behind the woodshed or give him a good "talking to." From then on he might not mention any more "bad words" but he would think about sex more than ever. (Sex is much more interesting when we make it obscene and forbidden.) Answer Johnny's questions directly and honestly. You will have taken away the false notion that sex is wrong and sinful, and his curiosity will be satisfied.

Some of our mental breakdowns are caused by the kind of a society in which we live—a highly competitive society in which there are few winners and many losers. The drive for success puts an added strain on living, and some can't survive the struggle. Everyone is in competition with everyone else—not only for economic gain, but for esteem, love, respect, and recognition. The impact of competition is felt even in the family. Brothers and sisters vie with one another for the affection of their parents, sons are rivals of their fathers for the affection of the mother, and daughters are rivals of the mother.

Competition brings with it hostility. Since everyone is a rival, we view one another as enemies, each seeking a share in the stake. Competition also brings with it feelings of inferiority because it means that the fear of failure haunts us. We feel that we must

succeed and our self esteem suffers if we fail. Hostility, fear of failure, a feeling of guilt, insecurity—these are the things out of which neuroses are made.

Our society places a great deal of stress on money. We must keep up with the Joneses. But the majority of us can't get all of the things we want. The result is frustration and dissatisfaction. For a still large number of persons our economic order has even more drastic consequences—the anxiety which comes from low wages and fear of unemployment.

Conflicts within our personality are often embedded in our culture. For example, on the one hand we are taught to love one another, and on the other hand everything is done to spur us on to success at the expense of our fellow men. We are told that we are free to make our mark on the world, but we find that we are limited and hedged in by social convention and circumstance. It is no wonder that these contradictions in our culture reflect themselves in our emotional life and pull us in opposite and wholly different directions.

We are trying to reduce these conflicts in order to provide a happy, normal life for all our people. Laws are passed to give us economic security and remove the fear of hard times. Our schools are placing less emphasis on competition and more on cooperation. We are beginning to recognize that every person has his own limitations, and his success must be judged in terms of his own particular abilities.

Parents are learning about child training and psychology. We are trying to help people make a success of marriage. Social workers are helping people with their personal and family problems and are also assisting courts, psychiatrists and schools in working with warped personalities. Teachers in public schools are taught to recognize emotional disturbances and how to deal with problem children in the classroom.

Industry is beginning to see why the mental health of workers is important. Enlightened personnel practices under the direction of a competent industrial psychologist and social case worker can serve as an effective prevention measure. Theological students are now being trained in many seminaries to understand psychiatric problems and get first-hand contact with mental disorders in clinical training courses.

These are all important steps toward cutting the toll which mental illness takes. But more needs to be done. Reprinted for Health Education Journal, April, 1948, p. 6.

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## EDITORIAL

The leading article in this journal showing certain trends in the field of health services and health instruction at the college and university level indicates on the whole an encouraging situation.

With eighty-two per cent of the institutions of college or higher rank employing one or more full time physicians for their health service, the general situation is good. So good in fact, that it would seem that colleges and universities not included in the eighty-two per cent have some explaining to do to their clientele, and some rationalizing to do if their consciences are to rest at all easy.

We realize that the salaries needed to secure the services of physicians have gone up enormously in the last half dozen years, but so have the incomes from increased student enrollment. This factor of increased enrollment with its accompanying crowding in classroom and in other facilities has increased enormously the need for increased medical supervision and services. What was perhaps adequate for 1500 full time students is not adequate for 5000.

Too, as the cost of medically trained services has gone up, the tendency to use lay teaching in the health field has increased. While much of this lay instruction in health is excellent, the note

of warning sounded by Dr. DeWeese in his closing paragraph merits careful thought. In some schools and colleges, the reaching out by laymen in an effort to secure control of medical services and of medical personnel presents an alarming picture.

Good intentions cannot safely take the place of medical training and skill—*C. H. K.*

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## ABSTRACTS AND NOTES

Increase (New York) State Aid to Crippled Children.—Beginning January 1 state aid to general and convalescent hospitals for rehabilitation of physically handicapped children was increased from $750,000 to $900,000 a year. The maximum daily rate for care of children in general hospitals was increased from $6.25 to $8.50, with the state paying half. New York City will pay the other half for its residents, and upstate the county will pay it. Maximum daily rate for care of children in convalescent hospitals is increased from $5 to $6 a day. During 1947 the number of physically handicapped children including spastics, paralytics and amputees cared for in hospitals with state aid was 5,600. Most of those assisted are under 21 years of age, but a small number of persons over that age who have suffered from poliomyelitis are eligible for treatment. *Journal American Medical Association,* January 8, 1949, p. 111

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**GIRLS' BASKETBALL.** To the Editor:—Does playing basketball injure girls? Some physicians say that it is too strenuous. Should basketball be avoided during menstruation?

*J. O. Heim, M.D., New Florence, Mo.*

Answer.—Basketball can be played safely by girls if the following precautions are taken: (1) Examination by a physician to determine fitness for strenuous exercise, (2) use of girls' rules, which limit activities to zones on the court, (3) assurance that the contesting teams are reasonably well matched in age, size and training and (4) proper control and supervision.

Basketball with these precautions should not be more dangerous for the girl than for the boy. Though some girls can play basketball during menstrual periods without difficulty, many others will find it wise to omit such strenuous exercise for the first day or two of each menstrual period. This individual difference can be determined only by personal experience. *Journal, American Medical Association,* January 8, 1949, p. 129.

**Toothbrushes,**—Americans use more toothbrushes than most of the rest of the world, but even in the United States a survey made some years ago showed that less than one-half the people have a toothbrush which they use regularly. There is evidence that very few people have two toothbrushes which they alternate at various times during the day. While the scientific evidence in support of brushing the teeth as a means of preventing caries or other disturbances is not too profuse or too well established, the use of the brush has met with almost universal approval by hygienists, dentists and physicians. Recently a survey was made of the average use of toothbrushes in the American home. New toothbrushes were offered to a selected sampling of American families who had sent in their toothbrushes then in use. Over 8000 toothbrushes were received, and more than 6500 were found to be inadequate and unsatisfactory for a variety of reasons. These included bent or broken bristles, matted bristles or unsatisfactory condition. About 2000 families participated. The average was 4.2 brushes per family. Since there were slightly less than 4 persons per family, it could be assumed that each member of the family had a toothbrush, but examination of the toothbrushes indicated that many of them were being used for other purposes than for brushing the teeth. More than 80% of the brushes were found to be in need of replacement because they could no longer be effective implements in hygiene of the mouth or because their condition was such that they might injure dental tissue. Almost 2000 brushes were found to be unsatisfactory because of caked dentifrices and food debris at the base of the bristles. Apparently there ought to be some sort of routine inspection and rehabilitation of toothbrushes like that given to motor cars, oil heaters and other domestic devices. The care of a brush of any kind should include thorough cleansing and drying after use and especially when debris accumulates. *Journal American Medical Association,* January 8, 1949, p. 102

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**Dr. Clair E. Turner,** Assistant to the President of the National Foundation for Infantile Paralysis, left New York on January 21st for two months in Iran. He is one of a group of experts being sent into the country by Overseas Consultants to study health, education, agriculture, transportation, industry and other phases of national life for the Iranian Government.

Dr. Turner has previously worked in most of the South American countries in the program of health and sanitation carried out by the Institute of Inter-American Affairs. He has also worked in India and China and has made professional visits to many other countries, including Egypt, Syria and Turkey.